CONFERENCE OF OPTHALMOLOGISTS
SERVING IN A SUPERVISORY OR
CONSULTATIVE CAPACITY TO STATE
WELFARE DEPARTMENTS

Hv2330
.C66 1938

AMERICAN FOUNDATION
FOR THE BLIND INC.

Conference of Ophthalmologists

Serving in a Supervisory or Consultative Capacity to

State Welfare Departments

Administering or Supervising the Administration of Aid to the Blind

Washington, D. C.
October 12, 1938

HV2330
C

AMERICAN FOUNDATION
FOR THE BLIND INC.

Conference of Ophthalmologists Serving in Supervising
and Consulting Capacity to State Welfare Departments
in Connection With the Program of Aid to the Needy Blind
October 12, 1938

Those present:

Dr. Clifford Mullen--Kansas
Dr. Cyrus W. Rutherford--Indiana
Dr. Claude Perry--Ohio
Dr. L. S. Powell--Kansas
Dr. W. J. Rein--Virginia
Dr. John O. Wetzel--Michigan
Dr. B. F. Jackson--Alabama
Dr. Oliver W. Turner--Maine
Dr. Clarence L. Kibler--South Carolina
Dr. Walter S. Shepherd--West Virginia
Dr. Grady C. Clay--Georgia
Dr. Frank W. Burch--Minnesota
Dr. Vonnie Hicks--North Carolina
Dr. Wm. H. Crisp--Colorado
Dr. Harold J. McCoy--Iowa
Dr. John Green--Missouri
Dr. Archie D. McCannel--North Dakota
Dr. C. E. Rice--Washington, D. C.

This conference was held during the annual meeting of the American Academy of Ophthalmology and Otolaryngology in Washington, D. C., October 9-14, 1938.

No definite outline of discussion to be followed was prepared, the idea being to permit anyone present to air any problems encountered in the medical phases of assistance to the blind or to remark about the success of any particular procedures or plans attempted. If any emphasis was to be made, it was hoped that it might concern the constructive possibilities of the work.

RESEARCH DEPT. LIBRARY

HV2330
C
cop.1

Dr. Mullen--In Kansas the first job was to designate competent men to examine. Several sources were used in getting the information about physicians skilled in diseases of the eye. Membership in several professional organizations was one source. These are: American Medical Association, Kansas Medical Society, Kansas City Eye, Ear, Nose, and Throat Society, American Academy, and Certificate by American Board of Ophthalmology.

Definite instructions were sent the designated examiners. One difficulty here has been that the doctors do not take the time to read what is sent them. It is believed that time is wasted in preparing and sending to the doctors any instructive material emphasizing error or carelessness that covers more than one point in any one letter or circular, after the first set of instructions and regulations have been given each; that is what we started doing--taking up only one point at a time.

About 10 men have been weeded from the first list, based on experience with their work and based on a questionnaire sent to all the approved examiners asking them whether they limited their work entirely to the eye, or eye, ear, nose, and throat.

Applicants have been allowed free choice of any ophthalmologist on the approved list when it comes to eye examinations or restorative work; however, when a reexamination is necessary, we designate the ophthalmologist for this reexamination. The supervising ophthalmologist must O. K. any surgical procedure.

Digitized by the Internet Archive
in 2015

https://archive.org/details/conferenceofopht00unse

The medical care provided is not limited to sight restoration only, but care is provided to prevent blindness. Helping in this phase of work is a public health nurse with several years' experience in social work. She has been of much aid in contacting the physicians, hospitals, and county directors cooperating in this program and keeping in touch with the necessary follow-up. She is familiar with nomenclature for classifying blindness. The follow-up work is a necessary adjunct to a successful program. The cooperation we have received from our Kansas State Board of Social Welfare has been a great help to us. It has been indeed a pleasant and interesting task.

It is required that all medical or surgical work in this program be done in hospitals approved by the American College of Surgeons. This is commencing to give us some trouble as there are several counties with small hospitals not so approved. Some of these hospitals have competent professional people connected with them and are doing good work. The question is, how can we let down the bars for some of these small institutions, without letting the bars down for all of them. We have not solved that problem.

A fee of $5.00 is allowed for our eye examinations and $75.00 for cataract operations. The doctor is not paid until the eye examination record has been accepted, and pay for surgery is not allowed until all records on the case are complete in the office. There has been some reduction in operative cases coming to the eye clinics at our medical school since the start of our restoration program. Only cases eligible for aid to the blind needing treatment are included in our restoration-of-sight program.

Dr. Powell--A committee of the Kansas State Medical Society was formed for the purpose of pointing up prevention of blindness. I am chairman of that committee. We have prepared 16 educational leaflets about eye conditions and proper eye hygiene. Some 3,000,000 of these pamphlets have been printed by the welfare department of the State and through the cooperation of the State department of education will be used in all the schools of Kansas. I will pass copies around to all of you and would like comments and criticisms now or by letter.

Dr. Green--I notice in your pamphlet under Crossed Eyes that you say, "If strabismus or crossed eyes develop, you should consult your family doctor immediately." Don't you think that is bad? Shouldn't you say, "Consult an ophthalmologist."

Dr. Powell--We were afraid that the average citizen would not be familiar enough with the term ophthalmologist, or eye physician, or oculist. We realize, of course, that there is much education yet to be done as regards the family physician or general practitioner concerning crossed eyes in infancy and early childhood.

Dr. Shepherd--We have thought it necessary in West Virginia to assume considerable responsibility in designating physicians to do operative work on the eye. This group is more limited than the group designated to examine eyes. We have also found that if we are not willing to pay a reasonable fee, then we will not get the best men to cooperate with us.

We have just finished a trachoma survey in cooperation with the State health department, and are fairly well along in our planning for a mobile clinic with a full-time clinician which will go into the hills and byways to find and treat those who suffer from this disease. As it is now, no private ophthalmologist in the State wants a case of trachoma to come into his office.

Dr. Kibler--We do not have the money in South Carolina to pay surgeons' fees as many of the States are now doing. We pay $5.00 for a thorough and complete eye examination. Our ophthalmologists have agreed to do all operations without a fee, and so far the end results have been very satisfactory. As to how long they will continue to do this I am not able to say.

We have about 50 designated eye physicians in the State, about half of whom are members of our State Society of Ophthalmology and Otolaryngology. We have a few of these members now on the designated list whose work is not entirely satisfactory from lack of skill and experience. These men should be eliminated, but how can we do it?

Dr. Mullen--In reply to Dr. Kibler's question would like to say that it is the responsibility of the supervising ophthalmologist. The advisory committee, which in our case is the eye committee of the Kansas Medical Society, should be consulted on such problems, as it acts as a stabilizing unit to recommend elimination of those ophthalmologists from the approved list who are careless or apparently unqualified. It also helps in the weeding-out process to establish a policy of designating only those who limit their practice to eye, or eye, ear, nose, and throat work.

Dr. Hicks--We don't have the money in North Carolina that we should have for a constructive program. We can only pay our examiners $1.00 for an eye examination. That is not enough. We have done quite a bit of sight restoration surgery and also much work on children who have squint and congenital cataract and bad refractive errors. This work has been done almost gratis by the profession. I want to point out the active support from the State public health people that has made much of our constructive work possible, especially in the schools.

We were too hurried in our first rush to examine the blind and near blind. I believe we should commence and do the work all over.

We have many Negroes in North Carolina and many whites that are quite a distance from qualified eye men. I believe the only answer in our State is a full-time mobile ophthalmologist. Not enough of us want to be bothered with Negro patients. They need competent service. A full-time person would help in accomplishing this.

We have got to get away from the idea that this program is planned for the benefit of the doctor. It has got to be planned for the benefit of those who need the service regardless of what we may feel about it. I am tired of hearing so much about State medicine and regimentation.

Dr. Rein--In Virginia the State agency interested in work with the blind and prevention of blindness has had a full-time ophthalmologist for some time. We work largely through the organized county health departments and hold diagnostic and refractive clinics throughout the State. I am serving also as supervising ophthalmologist

in the blind-aid program. Only one eye physician has refused any cooperation.

We are fortunate in the State in having a good medical school to which the eye surgery on adults and children can be referred without any professional fee being involved. This relationship and procedure has not been interfered with and we do not contemplate any change that will interfere with the use of this existing facility to its fullest extent.

* * * * * *

The question was raised at this point by one physician as to why the discussion was concerning itself with medical matters that seemed to be far removed from the blind-aid program. Was the crippled children's program also part of the discussion?

In reply to this question the point was made that some States had proceeded no further than giving assistance to the blind, in which case they would be concerned only with an adequate medical determination of blindness. In other States, the next logical step had been taken in providing machinery for restoring vision and providing medical and surgical care to prevent blindness even in children, while in still other States, such as Kansas, a third step had been taken by the State welfare department in concerning itself about educational efforts to instruct people about eye hygiene and prevention of blindness.

In some States there existed a close tie-up between the crippled children's program and the sight conservation efforts of the program for the blind, in that a child with squint or congenital

cataracts was considered a crippled child and so could be hospitalized and operated on under the crippled children's program. In one or two jurisdictions the medical advisory committee under the blind-aid program was also serving in advisory capacity to the crippled children's work insofar as that program concerned children with crippling eye conditions.

So the discussion could cover a very wide range when the constructive possibilities were being considered.

Dr. Crisp--Dr. Crisp stated that the full-time ophthalmologist in some States would be especially indicated. He believed very strongly in the idea that adequate fees be paid to the physicians when they are expected to cooperate in such work. The State will save money in the end by so doing.

They are working out plans, in cooperation with the State health department and the Colorado General Hospital, to provide diagnostic and refractive clinics for the more remote areas of Colorado. The ophthalmologists going out on such clinics will be paid a per diem of about $30. These clinics will work largely with school children. The State health department is providing most of the funds for paying the ophthalmologists and the travel expense of a medical social worker who will work with the county public health nurses.

In Colorado they had noticed considerable reduction, since the start of the social security program, in the number of cases needing eye surgery that are referred to the medical school eye clinic. Most of these patients, for whom the State department is assuming responsibility for eye care, are being sent to private hospitals.

Dr. McCoy--The indigent people needing these services should have them. However, in arranging such services, care should be taken to preserve existing arrangements that have grown up to feed cases into our teaching centers.

* * * * * *

The point was brought out here that one State, Connecticut, in its plan, is providing a fee of $5 for an eye examination and an additional $2 to the eye physician for taking blood for a Wassermann. A Wassermann is to be required on all new applicants and reexaminations. It was thought that this procedure would be worthy of consideration in other States.

Another point emphasized was that the Federal Government was contributing nothing to the constructive aspects of the blind-aid program, other than the financial grant to the individual. There was one possible exception to this statement. This concerned the 5% Federal grant for administrative purposes, which could be used for paying physicians for eye examinations.

The question was asked as to how many supervising ophthalmologists had commenced to use the standard nomenclature for classifying causes of blindness which was approved by the Ophthalmological Section of the American Medical Association in June. Apparently eight of those present were using such. Two indicated that it would hardly be possible for the local examiners to make use of this classification. At least, the supervising ophthalmologist should not expect a proper application of this classification by the local examiners in very many cases. They thought that if the classification appeared on the

back of the eye form or had been sent to the examiner in a bulletin, the supervising ophthalmologist should check as to the proper application of the classification.

Dr. Perry--Dr. Perry indicated that, although he has been using the classification for over a year, he still thought more time should elapse before any thought was given to attempting to collect from the States any statistics as to causes of blindness. He stated that they were now using a punch card that would permit machine tabulation of causes of blindness, tabulation of cases by counties, and tabulation of operative results.

Dr. Perry thought some modification of the definition of blindness in ophthalmic units was indicated. He stated that he personally would prefer 20/200 visual acuity with accommodation than 20/70 without accommodation. So why not include a statement in definition that an aphakic eye with 20/70 visual acuity with proper correction would be considered a blind eye or comparable to an eye with 20/200 central visual acuity.

He stated that some experience was had in Ohio with the use of teams of eye surgeons going to some outlying point and operating on a group of cases. The operated cases were of necessity left in the hands of nurses and surgeons not very familiar with the postoperative care of cataracts. The results led to a rapid discontinuance of the practice.

Dr. Perry subsequently called attention to a recently developed, coordinated eye service in Ohio (i. e., correlation of the preventive program of the Ohio Commission for the Blind with the investigative and

financial aid program of the State and county public assistance units), which has been established and developed as city- and county-wide school eye surveys. The direct result of this has been a marked decrease in the percentage of school failures in such districts where these surveys were conducted. There is also a reported lessening of the disciplinary problem in at least one city school system.

CONCLUSIONS

The following points of interest were brought out in the discussion:

1. The supervising ophthalmologists and their advisory committees should take responsibility for advising the welfare administration concerning elimination of careless ophthalmologists from the approved list.

2. It is possible that lengthy instructions issued to physicians covering several points, fail in their purpose because the doctors do not read them. Short letters covering one point might be better.

3. Prevention of blindness and sight restoration are natural developments of the program of aid to the needy blind. There is possibility of close tie-up with the crippled children's program.

4. There is a problem yet unsolved as to how State welfare departments can approve rural hospitals doing good work without letting down the bars to all such institutions.

5. Should there be a separate designation of physicians approved for doing eye surgery on the indigent?

6. Some States should consider the advisability of a full-time ophthalmologist as an aid in their sight conservation work.

7. Wassermann reports should be required on all new applicants and reexaminations. A special fee should be provided for such.

8. Care should be taken that the medical teaching centers do not suffer for want of suitable eye cases as a result of plans made by State welfare departments to provide machinery to restore vision in needy persons.

9. Supervising ophthalmologists should soon commence to apply the Standard Classification of Causes of Blindness.

10. It is probably too soon to think of securing reports from States as to causes of blindness. Examination reports must improve first. This might not apply to all States.

11. Sending teams of ophthalmologists to outlying points to do eye surgery may be a questionable procedure unless certain precautions are observed.

12. A question not raised at the conference, but discussed individually with some of those present concerned the idea of attempting in one or more States to make blindness in one or both eyes a reportable condition, reportable to some public agency at the time blindness occurs, such reporting to show name, address, age, sex, visual acuity, and cause of blindness. This would mean reporting private cases as well as clinic cases, such reports to be confidential. It might be well to discuss this point with advisory committees. Comments are requested concerning this question.

July 14, 1938

My dear Doctor:

In the development of the Assistance to the Blind work, a division of the Old Age Assistance, it has been our desire to make the work in Connecticut outstanding. Because of the small area of our state and its fairly evenly distributed population, Connecticut can well be a valuable laboratory for social work.

In view of the present wide-spread interest and publicity concerning the venereal diseases, we have felt that it would be worth while to have a Wassermann, or other reliable serological test, made on every applicant for Blind Assistance. This would enable us to compute reliable figures on the relation of the venereal diseases to blindness in our own state, and also afford an opportunity to investigate other members of the family of the applicant who has syphilis. In this way the Social Service workers could extend their valuable aid in helping more unfortunates and in wiping out the venereal diseases.

We have hesitated to require the examining ophthalmologists to take material for a blood test in all cases without offering some further compensation. When these facts were explained to Commissioner Walcott, he promptly agreed to the allowance of an additional fee of two dollars for the blood test on each applicant. Therefore, in all future cases, a report of the blood reaction will be required. If you send in your examination sheet before the blood test report comes in, please be sure to forward it as promptly as possible. These reports must be sent in duplicate to the Ophthalmological Consultant, as are the other reports.

Sincerely yours,

EUGENE M. BLAKE, M.D.
Ophthalmological Consultant

Letter sent to the local Examining Ophthalmologists of the State of Connecticut by the Supervising Ophthalmologist.

STATE OF CONNECTICUT
OFFICE OF COMMISSIONER OF WELFARE
BUREAU OF OLD AGE ASSISTANCE
HARTFORD

July 14, 1938

To: EXAMINING OPHTHALMOLOGISTS

Subject: ASSISTANCE TO THE BLIND - LABORATORY TESTS

Effective July 15, 1938, Examining Ophthalmologists will have a laboratory test made on each applicant for blind assistance in conjunction with the initial eye examination.

An additional fee of $2.00 will be allowed for each test, the billing for which will be included with the established $5 fee for eye examination. As outlined in previous instructions, all bills will be submitted on a monthly basis.

The report of the test, as explained in Doctor Blake's letter attached, will be sent in duplicate, to the Consultant either together with the eye examination report or separately as promptly as possible.

(Signed) E. H. Reeves
Director

r/rls

HV2330 CONFERENCE OF OPTHALMOLOGIS c.1
C TS SERVING IN A SUPERVISORY OR
CONSULTATIVE CAPACITY TO STATE WEL-
FARE DEPARTMENTS.

Date Due			